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ABSTRACT

Investigations of the reformulated learned helplessness model of depression have produced conflicting results. To contrast the attributional responses of clinically depressed men and women, data were collected from 117 psychotherapy clinic outpatients. An expanded version of the Attribution Style Questionnaire was administered. Forty people similar in most of the covariates measured, except being currently in therapy, served as controls. Results showed that clinically depressed subjects reported more self-attributional replies than controls; however, some of them claimed more credit for success than responsibility for failure, a finding inconsistent with the model. Severely depressed subjects, as expected, assumed more personal responsibility for their negative life events, although the degree of responsibility did not correspond to degree of depression, suggesting the kind of depression rather than the degree may be more relevant to the model. Females more than males blamed themselves for negative life experiences, indicating that the respondents' sex more than degree of depression related to both the event and the extent to which self-attributional responses were made. (JAC)

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THE REFORMULATED LEARNED HELPLESSNESS MODEL OF DEPRESSION----REVISITED.

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Title: The Reformulated Learned Helplessness Model of Depression---Revisited.

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Summary

The reformulated learned helplessness attributional model of depression was evaluated in terms of degree of clinical depression, respondents' sex, and the nature of the events in question, i.e., good/bad. Significan main effects were demonstrated for all three variables, but the significant two and three-way interactions were more enlighting. While the results basically support the model's predictions, e.g., that clinically depressed Ss assumed more personal responsibility than nondepressed Ss for their life outcomes, the to which this occurred was a function of an obtuse and complex interdependency among the variables studied, especially, the respondents' sex. Discussion focused on the needs for cautious conclusions and for further refinement of the model.

Problem

Investigations of the reformulated learned helplessness model of depression which postulates that bad outcomes are attributed to internal, stable, and global causes (Abramson, Seligman, & Teasdale, 1978) have produced conflicting results

(e.g., Seligman, et. al., 1979; Blaney et. al., 1980; Hammen & Cochran, 1981; etc.). Explanations offered to account for these findings, methodological considerations not withstanding, have focused on the hazardousness of attempting to generalize from mild depression measured in a college sample to clinical populations; the two many not only differ in degree but also in kind (e.g., Arieti & Bemporad, 1978; Deupe & Monroe, 1978, etc.)

The few studies which have evaluated the model in clinical settings have also yielded equivocal outcomes. Goung-Guy & Hammen (1980) using outpatients found partial supoort for the model's predictions but only for the most stressful events about which attributions were made. More recently, Raps, et. al., (1982), were able to differentiate hospitalized unipolar major depressed males from comparable nondepressed schizophrenics and medical/surgical patients. Their results showed not only that unipolar depressed patients held themselves responsible for all outcomes, but were also "evenhanded" in attributing both success and failure to themselves; whereas, other research has shown nondepressed individuals tend to view success as internal and failure as external (Alloy & Abramson, 1979). Raps, et. al., (1982) also concluded that while their findings were supportive of the depressive attributional style stipulated by the model for clinically depressed males, they did not consider them to be characteristic of psychopathology in general. Given the non-representativeness of psychopathology in their study, such a

conclusion is not only unfounded but also misleading; especially, since the extent to which a continuity of attributional style exists among all depressives, still remains unsettled.

The present study, therefore, explored the reformulated learned helplessness model of depression by contrasting the attributional responses of both males and females diagnosed according to the DSM-III (APA, 1980) as either Adjustment Disorder with Depressed Mood, Dysthymic Disorder, or Unipolar Major Depressive Disorder. The question of whether "evenhandedness" characterized the attributional style of Ss as well as the nature of the attributional events being considered were also examined. And, while support for the model's predictions was expected, no specific hypotheses were advanced given the contradictory data cited in the literature (e.g., Alloy & Abramson, 1979; Blaney et. al., 1980; Gong-Guy & Hammen, 1980; Hammen & cochran, 1981; Peterson, et. al., 1982; etc.).

Method

Subjects

Data randomly collected from 117 (N) outpatients receiving psychotherapy at five different clinics located in Suffolk County, N.Y. were used in the analyses. S selection was in keeping with the Raps, et. al., (1982) study. Only Ss who scored 8 or higher on the Beck Depression Inventory (Beck, A.T. & Beck,

R.W., 1972) and were formally diagnosed by psychiatrists (11 were involved) in accordance with the DSM-III as either (ADDMO Adjustment Disorder with Depressed mood, n = 33, females = 16, males = 17; (DD) Dysthymic Disorder, n = 48, females = 30, males = 18, or (UMDD) Unipolar Major Depressive Disorder, n = 36, females = 21, males = 15. Also Ss' age, income (earned & unearned), education, length of treatment, and marital status were assessed as possible confounding covariates.

The ADDM group was characterised as follows: age, $\bar{X}$ = 32.2 years; income, $\bar{X}$ = $17,367 annually; education, $\bar{X}$ = 13.9 years; length of treatment, $\bar{X}$ = 20 weeks; and marital status; 70% married, 18% divorced, and 12% single. Data for the DD group were: age, $\bar{X}$ = 40.6 years; income, $\bar{X}$ = $19,927 annually, education, $\bar{X}$ = 12.1 years; length of treatment, $\bar{X}$ = 32 weeks and marital status; 65% married, 30 % divorced, and 5% single. The UMDD groups' data were: age, $\bar{X}$ = 49.7 years; income, $\bar{X}$ = $18,533 annually; education, $\bar{X}$ = 10.9 years; length of treatment, $\bar{X}$ = 58 weeks, and marital status; 51% married, 45% divorced, and 3% single.

Instruments

The Attribution Style Questionnaire (Peterson, et. al., 1982) was administered to all Ss; but, as Raps, et. al., (1982) suggested, it was expanded to improve its reliability. The revis-

ed questionnaire contained 18 statements in contrast to the original 12 but kept the same form: "You have been looking unsuccessfully for a job for a long time...". 1) Write down one major cause. Questions 2-4 measured, on a scale ranging from 1-7, internality (1 = external; 7 = internal), stability (1 = atypical; 7 = usual), and globality (1 = this event; 7 = all the time). Half of the 18 questions depicted good events; half were of bad outcomes which were randomly intermixed to control for any contaminating order effects. Test-retest reliability over a 10 week period yielded reliability coefficients for composite scores of .89 for good events and .91 for bad outcomes, an improvement over Peterson's, et. al., (1982). Using Peterson's, et. al., (1982) computational procedure an evenhandedness score which reflects the extent to which Ss responded similarly (without bias) to both good and bad outcomes and is not redundant.

Procedure

Since the 40 people who voluntarily participated in revising the original questionnaire were comparable to the clinical Ss in terms of most the covariates meeasured, e.g., age, education, etc., except for not being currently in therapy, they also served as a non-clinical control group. None of the control Ss, who were recruited from a variety of settings, scored higher than 6 on the Beck Depression Inventory.

Only clinical sample Ss whose therapist (23 were involved) were interested in partaking in the research project and who met the criteria described were apprcached and asked to particapte; all agreed. Ss were verbally instructed by their therapist during one of their regular session to "Please try to vividly imagine yourself in the situations described..." Directions were also in writing as well and Ss were told they would be given feedback once the data was analyzed.

Results

The covariates measured, e.g., age, education, etc. proved to have no bearing on the data, so ANOVAS rather than ANCOVAS were employed. And, prior to evaluation of specific scores an overall multivariate analysis (MANOVA) was computed on the attributional dimensions, i.e., internality, stability and globalability and this study's experimental variables. The outcome was highly significant, $p < .001$; but, given the voluminosity and complexity of the data, the results reported herein are restricted to a 2 x 3 x 3 harmonic mean ANOVA of composite scores which are recorded in Table 1. Unless otherwise indicated all significant differences cited were found at either the .05 or .01 levels.

INSERT TABLE 1.

The overall findings support the attributional prediction offered by the reformulated learned helplessness model for depression. Using Winer's statistical procedures (1974) for nested factorial designs, significant composite score differences were found between the clinically depressed sample, $\bar{X}^2 = 5.30$ and the control sample, $\bar{X} = 4.68$, $t(1, 324) = 3.94$, $p<.01$, indicating that the clinically depressed Ss, collectively, assumed more personal responsibility for their life outcomes (good and bad) than the control Ss.

In addition, significant main effects were evidenced for all three variables examined: namely, degree of depression (Dx), $F(2, 93) = 6.82$, respondents' sex, $F(1, 93) = 7.73$ and nature of the attributional events in question, $F(2, 306) = 4.81$. Since significant two and three-way interactions were also discovered between: Dx and the attributional events, $F(4, 306) = 4.31$ and respondents' sex and attributional events, $F(2, 306) = 4.91$ and among all three, i.e., Dx, Sex and attributional events, $F(4, 306) = 5.34$, tests for simple main effects rather than overall differences were conducted.

With respect to bad life outcomes, discounting respondents' sex, all three Dx groups differed significantly from each other. The DD group accepted the most personal responsibility for their bad life experiences, followed by the UMDD group and then the ADDM group, $F(4, 306) = 4.39$. In fact, the ADDM group actually credited themselves more for their success than for their fail-

ures, $F(4, 306) = 5.01$; whereas, both the DD and UMDD groups assumed more personal responsibility for the bad experiences in their lives in contrast to the good ones, $F(4, 306) = 4.55, 4.12$ respectively. And, while the UMDD group reported more credit for their successes than the DD Ss, $F(4, 306) = 4.44$, as previously indicated both accepted more blame for their failures than they accepted credit for their successes. All of the Dx Ss revealed biased responses with the ADDM Ss disclosed the least biased of the three groups, $F(4, 306) = 4.23; 4.19$, respectively, followed by the UMDD group, who were less biased then the DD $F(4, 306) = 4.36$. The DD group disclosed the most bias.

When the Dx groups were collapsed and the attributional events looked at in terms of respondents' sex, females, in contrast to males, were found to assume more personal responsibility for life's bad outcomes, $F(1, 306) = 7.88$. They were also considerably more evenhanded, less biased, than males whose responses were quite lopsided, $F(1, 306) = 10.45$. The reverse was demonstrated for good outcomes,i.e., males reported more responsibility than females for their successes, $F(1, 306) = 6.32$.

The three-way interaction revealed significant differences between/among most cell comparisons, but, for the sake of brevity, only some will be highlighted. Most of the cell differences related more to the respondents' sex than to their Dx. The only instances where sex did not play a role involved the ADDM and DD groups. Insterextingly, both males and females ADDM Ss reported

more responsibility for their successes than for their failures, eventhough the difference was smaller for females than for males. Similarly, both males and females DD Ss assumed more responsibility for their failures than for their successes; however, females' assumption of blame for negative events was considerably greater than males. In general, males accepted less responsibility for bad vs. good outcomes, especially in comparison to females; although, males in the more severely depressed groups, male assumed equal, if not more responsibility for bad vs. good events. Females, still accepted consistently more blame for bad events than males and than accepting credit for successes, for most Dx categories. In fact, female DD Ss reported the highest self-blaming attribution score for bad outcomes recorded in this study, $\bar{X}$ = 6.40 (out of 7). While the second highest score, X= 6.24 was found by male ADDM Ss who credited themselves for successes, not failures, $\bar{X}$ = 6.24, this pattern was inconsistent with the other male scores; whereas the female score pattern was much more stable and global.

Discussion

While the general findings of this investigation are consistent with outcomes reported in the literature (e.g., Abramson et. al, 1978; Seligman, et. al, 1979; Gong-Guy & Hammen, 1980, Peterson, et. al., 1981; Raps, et. al., 1982; Peterson, et.

al., 1982), the data points out the need for a better understanding of the variables, aside from depression and the attributional event, which may contribute to the specific attributional response a person makes.

While, as indicated by the model, clinically depressed Ss reported more self-attributional replies than the nondepressed control sample, not all of the clinically depressed Ss assumed personal responsibility for their bad experiences. In fact, some claimed more credit for their successes than responsibility for their failures, a finding inconsistent with the model's tenets. However, the more severely depressed groups assumed, as expected by the model, personal responsibility for their negative life events; yet, the degree of assumed responsibility did not correspond to the degree of depression. The Dysthymic Disorder Ss evidenced more self blame than the more severely depressed UMDD Ss, raising once again the question regarding whether differences in degree of depression reflect different "kinds" of depression (Arieti & Bemporard, 1978; Deupe & Monroe, 1979, etc.). The kind of depression rather than the degree may be more relevant to the model.

Furthermore, this study's results indicated that the respondents' sex, more than degree of depression, related to both the extent and the event to which self-attributional responses were made. Females, by and large, blamed themsives more than males for their negative experiences; while the reverse was true

for males. Even the more severely depressed males reported less responsibility for bad outcomes than females. And, while it was the females who responded with more self blame for negative life outcomes, it was not the most severely depressed females who reported the most self-blame. Even though this finding fits the model's parameters, little if any, research attention has been paid to the effect of sex role on attributional responses, aside from those studies involving casual attribution and achievement which produced outcomes similar to the present data (Bar-tal, et. al., 1977, Feather, et. al., 1978, etc.).

Further elaboration of the data is not possible given the space limitations, except to say that while several hypotheses may be offered to explain the present data, the question that really needs to be addressed is what are the specific factors which identify the depressed patients who may benefit most from the application of the reformulated learned helplessness model of depression.

Table 1.
Mean Attributional Score

	BAD(a)	GOOD(a)	EVENHADED(b)(c)	TOTAL
MALE ADDM	4.01	6.24	5.69	5.31
MALE DD	5.57	4.42	6.62	5.54
MALE UMDD	5.66	5.56	5.72	5.65
MALES X	5.08	5.41	6.01	5.50
FEMALE ADDM	4.81	5.14	4.65	4.87
FEMALE DD	6.40	4.85	4.71	5.32
FEMALE UMDD	5.49	4.88	4.89	5.09
FEMALE X	5.57	4.96	4.75	5.09
TOTAL	5.33	5.19	5.38	5.30
ADDM	4.41	5.69	5.17	5.09
DD	5.99	4.64	5.67	5.43
UMDD	5.58	5.22	5.31	5.39
MALE	5.08	5.41	6.01	5.50
FEMALES	5.57	4.96	4.75	5.09

a=higher scores indicate greater self-attribution
b=higher scores indicate greater bias.
c=higher scores reflect bias; lower score evenhandedness.

Footnotes

1 = F_{max} test was not significant.

2= the higher the score, the greater the self attribution.

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